DEPARTMENT OF HEALTH AND FAMILY SERVICES
HFS-9 (Rev. 04/03)

STATE OF WISCONSIN
Sections 19.35 & 19.36, Wis. Stats.

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION I

(6/03)

Completion of this form authorizes the release of information described in the section below called "Specific Description of Records Authorized for Release". The person (record subject) whose records are released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication / somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances. Section 51.30, Wis. Stats., HFS 92.03-92.06 Wis. Adm. Code.

Name – **Person Whose Records Will be Released (Record Subject)** (Adoptive Parents)

Address

City, State, Zip Code

Identifying Number (If Any): Not Applicable

Date of Birth: Not Applicable

Name and Address – **Agency / Organization I Authorize to Release Information**

Name - **Information May be Released To**: Post Adoption Service Centers

Organization

Address

City, State, Zip Code

Specific Description of Records Authorized for Release (Include dates of records, if applicable)

Adoptive Parent(s) name and mailing address.

Purpose or Need for Release of Information (Be Specific)

Name / address provided will be released to the appropriate Regional Post Adoption Service Center in the area of the state in which I live and the Special Needs Adoption Network in Milwaukee.

Understandings

- This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefits eligibility except for:
  ☐ No exceptions ☐ Exceptions (specify):
- The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- I may revoke this authorization, in writing, at any time except for information already released as a result of this authorization. The written revocation must be given to the agency/organization I authorized to release information.
- Unless revoked, this authorization will remain in effect until the expiration time indicated below.

Choose One:

☐ Authorization expires as of (Date).

☐ Authorization expires month(s) from the date I sign this authorization.

X Authorization expires after the following action takes place: I / we no longer have an Adoption Assistance Agreement with the Department of Health and Family Services.

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

SIGNATURE - Person Whose Records Will be Released (Record Subject) | Date Signed

SIGNATURE - Other Person Legally Authorized to Consent to Disclosure | Title or Relationship to Record Subject | Date Signed